NHS England

Date published: 26 September, 2024
Date last updated: 2 October, 2024

Primary care patient safety strategy

Implementation of the NHS patient safety strategy in primary care.

Publication (/publication)

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Summary

Primary care – general practice, community pharmacy, optometry and dental services – delivers 90% of NHS interactions, face to face, by phone or online. The overwhelming majority of these are safe, but with between 20,000 and 30,000 incidents of avoidable significant harm identified in general practice in England per year, there is opportunity to continue to improve the safety of care in primary care. We also know that incident data may be an underrepresentation of harm, as incident recording systems are not as well developed in primary care when compared to secondary care.

The NHS Patient Safety Strategy (2019) (https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/), the first national strategy for improving patient safety, applies to all sectors. However, we recognise it needs more specific interpretation for primary care. This Primary care patient safety strategy describes the national and local commitments to improve patient safety in primary care, supporting all areas in this sector to fully implement the NHS Patient Safety Strategy. It has been informed by the patient safety discovery group comprising: primary care providers, commissioners and patient safety partners from across general practice, community pharmacy, dentistry and optometry. This strategy draws together best practice. It is not a contractual requirement on primary care providers, or integrated care boards (ICBs). NHS England will continuously review its effectiveness and how we can best implement the strategy to improve patient safety.

It focuses on:

1. developing a supportive, learning environment and just culture in primary care, with sharing across the system so that the services can continually improve
2. ensuring that the safety and wellbeing of patients and staff is central, and that our approach to managing safety is systematic and based on safety science and systems thinking
3. involving patients in the identification and co-design of primary care patient safety ambitions, opportunities and improvements

Given the capacity pressures in primary care and ICBs, this strategy seeks to continuously improve patient safety through existing processes and structures as much as possible, rather than adding work. The timeframes for the implementation of the local commitments are intentionally flexible to allow for the piloting of different approaches, and while this strategy is for all areas of primary care, some improvements will be implemented first in general practice and the successes and learning then used in the rollout to community pharmacy, optometry and dental services.

In summary:

- safety culture: participate in the NHS staff survey
- safety systems: complete patient safety syllabus training
- insight: register for and use the new incident recording (LFPSE) and incident response (PSIRF) systems
- involvement: identify patient safety leads and lay patient safety partners
- improvement: review and test patient safety improvements in diagnosis, medication, referrals, optometry and dental services

Patient safety in primary care

This strategy outlines the primary care implementation of the NHS Patient Safety Strategy, and is for all areas of primary care, though with some improvements implemented first in general practice to enable the successes and learning to be used in the rollout to community pharmacy, optometry and dental services. We identify the local and national commitments that will support patient safety improvement across primary care.

Primary care is delivered to millions of patients via face to face, phone, video and online interactions every year across general practice, community pharmacy, dental services and optometry. While the overwhelming majority of interactions are safe, between 20,000 and 30,000 incidents of avoidable significant harm have been identified in general practice in England per year (Avery et al, 2020 (https://qualitysafety.bmj.com/content/30/12/961)). Every one of these incidents has a personal cost to patients, service users, families, carers and staff, as well as a financial cost to the NHS; a single significant harm episode in primary care is estimated to cost £5,000 (NHS Patient Safety Strategy, 2019 (https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/)), which means a total cost across primary care of over £100 million a year.

The top 3 patient safety incident types in the (Avery et al, 2020 (https://qualitysafety.bmj.com/content/30/12/961)) retrospective general practice case note review were:

- diagnosis 61%
- medication-related 26%
- delayed referral 11%

The new approach in patient safety is that when things go wrong in care and when things go right, it is important that patient safety events are recorded so the learning will continually improve patient safety: locally, at place, across systems and nationally. However, we know that the culture of incident recording from primary care is relatively underdeveloped and quite variable compared to secondary care, which means there will be areas of patient safety that we do not yet understand. Less than 1% of the 2.2 million incidents recorded nationally each year are from primary care, despite this being where most patient interactions take place. Also, 21% of all new claims to NHS Resolution (https://resolution.nhs.uk/) are from general practice (as reported in the new CNSGP and ELSP claims notified in 2023/24 (https://resolution.nhs.uk/corporate-reports/)). Chohan et al, 2022 (https://pubmed.ncbi.nlm.nih.gov/35396430/) identified that 48% of dentists did not know how to record an incident and that fear of repercussions was a key barrier to incident recording for 74% of dentists.

Diagnosis: Jessica's story

As told by her parents Simon and Andrea.

"Our precious daughter, Jessica, died on 20 December 2020. She was 27 years old.

She had been ill for 6 months, but the spring/summer lockdown meant face-to-face consultations with her GP were restricted and numerous antibiotics were prescribed, even in the absence of a physical examination. Jessica was told for months she was suffering from Long Covid despite two negative coronavirus tests. She was finally diagnosed with cancer on 26 November. Her dependency upon oxygen from this date meant she did not leave the hospital or ever return home. We discovered that Jess had stage 4 adenocarcinoma with an unknown primary. It had spread throughout her body, to her spine, liver, stomach, lungs and lymph nodes. The scale of missed opportunities, misdiagnosis and distress Jess experienced is heartbreaking. Jess was fighting two battles; on the one hand coping with her debilitating symptoms and on the other persuading anyone to listen to her. Jess was exhausted and, even at her lowest ebb, was forced to advocate for herself. Her eventual diagnosis was made via a private referral. We are obviously devastated."

Jessica's parents are campaigning for Jess's Law. The premise of Jess's law is: if after 3 consultations a patient's condition remains unresolved, or their symptoms are escalating and/or they have no substantiated diagnosis, their case should be elevated for review and a new assessment made: '3 strikes and we rethink'.

They are petitioning to improve the awareness and diagnosis of cancer in young adults (https://www.change.org/p/jess-s-law-improve-the-awareness-and-diagnosis-of-cancer-in-young-adults?recruiter=928989123&recruited_by_id=e81d3f31-1502-4ce3-9582-750cbae54156&utm_source=share_petition&utm_campaign=share_petition&utm_medium=copylink&utm_content=cl_sharecopy_27054559_en-GB%3A4) and have set up the Jessica Brady CEDAR Trust (https://jessicabradycedartrust.org.uk/), which raises funds "to support earlier cancer diagnosis within primary care".

We know that patient experience and staff wellbeing impact on patient safety, and both have been affected by resourcing and capacity pressures in primary care. In the GP patient survey 2023 (https://www.gp-patient.co.uk/surveysandreports) over a quarter (27.7%) of patients said their overall experience of making an appointment was poor (in comparison to 15.9% in 2019) and 14.2% said their whole experience was poor (6.5% in 2019). Significant access issues also exist for dental services identified in the House of Commons Health and Social Care Committee Dentistry report (2023) (https://committees.parliament.uk/publications/40901/documents/199172/default/), with nearly 6 million fewer courses of NHS dental treatment provided in 2023 than in 2019 (https://www.nuffieldtrust.org.uk/research/bold-action-or-slow-decay-the-state-of-nhs-dentistry-and-future-policy-actions).These poor experiences mean that people feel discouraged, excluded and disempowered and so disengage and are less likely to seek timely treatment.

In order to improve patient safety, there needs to be an underpinning operational approach to improving access and resources. This was identified in the Fuller stocktake report in 2022 (https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/) which indicated that both patient and staff satisfaction were low and that the three essential elements were: access to primary care, proactive personalised care and helping people stay well for longer. These 3 elements are also crucial to supporting quality and patient safety. Following this, the delivery plan for recovering access to primary care (https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/) (known as PCARP) published in 2023 and supported by the National General Practice Improvement Programme (https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/), focused on the operational aspects of the system, including workforce and capacity which are the fundamentals for supporting a safety culture and working environment.

Modern general practice, as outlined in PCARP, is improving inclusive primary care access (Chappell et al, 2023 (https://bmjopen.bmj.com/content/13/8/e072944)) with equity across a variety of contact routes (online, telephone, in person) and using one care navigation, triage and workflow process (https://www.england.nhs.uk/long-read/how-to-improve-care-navigation-in-general-practice/) to support fairer and safer prioritisation of care. This includes designing for continuity of care supported by digital technology and data.

Both of these reports are centred on access to primary care, and it is now becoming even more apparent that continuity of care (https://www.rcgp.org.uk/Blog/Continuity-of-Care-work-at-RCGP) in general practice can strengthen and support access by reducing the need for repeated patient contacts so that we can further improve patient safety. Continuity of care supports developing trust between a patient and their GP and enhances the GP's understanding of their patient's circumstances (Youens et al, 2021) (https://www.springermedicine.com/statins/care/regularity-and-continuity-of-gp-contacts-and-use-of-statins-amon/21829612) thus improving patient safety. For those patients who have more than 4 consultations over 2 years, it could save 5.2% of GP appointments (Kajaria-Montag et al, 2022 (https://www.insead.edu/faculty-research/publications/working-papers/continuity-care-increases-physician-productivity)) and avoid hospital admission (Barker et al, 2017 (https://www.bmj.com/content/356/bmj.j84.long)).

Safety culture, safety systems and inequalities

A positive safety culture is defined (https://www.england.nhs.uk/publication/safety-culture-learning-from-best-practice/) as one where the environment is collaboratively crafted, created and nurtured so that everybody (individual staff, teams, patients, service users, families and carers) can flourish to ensure brilliant, safe care. However, staff in primary care sometimes feel unsafe and unsupported by the culture and systems that surround them. By systems we mean the structures and processes within a practice, the organisational arrangements that surround a practice, the wider interactions with other providers of health and social care, and the influence of regulatory bodies.

There are two myths that can undermine a safety culture, both of which are held at times within primary care:

- perfection myth: if we try hard enough, we will not make any errors
- punishment myth: if we punish people when they make errors, they will not make them again

Both can instil fear and lead to the 'individual approach' to patient safety – where the focus is on some aspect of the person or their role in what goes wrong. It is necessary to recognise that healthcare staff operate in complex systems, want to do a good job and should be able to rely on the wider system to help them be successful and safe. Focusing on the action or inaction of one person ignores the risks in the system that allowed the incident to occur. Improving safety requires us to improve the safety of systems of work, and not to focus on individuals.

Primary care providers are responsible for the safety of their patients and sharing local information about risks and best practice. In this they are supported from neighbourhood and place to system level through integrated care systems (ICSs) to ensure the provision of safe care and tackle problems that cut across care settings, including safety risks when a patient transitions from primary care to another sector, and back again.

Action on patient safety also improves equality in healthcare as there is evidence that population groups experience patient safety events unequally (Wade et al, 2022 (https://www.bmj.com/content/376/bmj-2021-067090)). General Practice in particular has an essential role to play in addressing inclusion health, working in partnership to manage long-term conditions and to prevent ill health, which includes promoting patient safety, amongst socially excluded groups. This is supported within the 5 principles of the national framework action on inclusion health (https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/) that include delivering integrated and accessible services and we know that when we achieve this patient safety is improved for all. The COVID-19 pandemic highlighted the gaps in healthcare for people from groups who face inequalities, such as those on low incomes and from minority ethnic backgrounds who find it harder to afford and access dental care (Healthwatch, 2024 (https://www.healthwatch.co.uk/news/2024-02-01/our-position-nhs-dentistry)).

Ambitions

To support our patients' journeys through healthcare, we want to improve communication between the different areas of primary care, and between primary care and secondary care, mental health, ambulance, community care, social care and the voluntary, community and social enterprise (VCSE) sectors. We know that patient safety events are more likely to occur at these points of change and we want to develop a primary care culture with leadership that promotes an enabling and psychologically safe environment that extends across boundaries, as described in the next steps for integrating primary care: Fuller stocktake report (2022) (https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/).

The new National Care Records Service (NCRS) (https://digital.nhs.uk/services/national-care-records-service), which replaced the Summary Care Record application in 2024, helps with this ambition. Ultimately, any authorised clinician, care worker and/or administrator in any health or care setting (including general practice, community pharmacy, optometry and dental services) will be able to access a patient's information to support direct care.

We want to promote a culture of safety event recording in primary care, together with an improved learning response. This is encouraged by moving to a just culture (https://www.england.nhs.uk/patient-safety/a-just-culture-guide/) that focuses on the role of systems, not individuals, when things go wrong, a systems approach to solutions and compassionate leadership. And primary care needs to engage and involve patients, families and staff following a patient safety incident (https://www.england.nhs.uk/patient-safety/incident-response-framework/engaging-and-involving-patients-families-and-staff-following-a-patient-safety-incident/).

Alongside work in primary care, regulatory bodies such as the Care Quality Commission (CQC), General Medical Council (GMC), General Dental Council (GDC), General Pharmaceutical Council (GPhC), General Optical Council (GOC), Nursing and Midwifery Council (NMC) and performance advisory groups (PAGs) need to promote a systems approach as the proportionate response to patient safety incidents.

For example, Project Sphere, (https://www.england.nhs.uk/primary-care/dentistry/leading-the-change/patient-safety/) a working group led by the chief dental officer for England that seeks to improve patient safety across dentistry, has worked with defence and indemnity organisations to produce an indemnity consensus statement (https://cgdent.uk/indemnity-consensus-statement/) around moving from a blame to a learning from events culture.

Referral: Patient S's story

Taken from the Coroner's Prevention of future deaths report (https://www.judiciary.uk/prevention-of-future-death-reports/serena-roberts-prevention-of-future-deaths-report/)

"Patient S died in 2021 from a complication of ovarian cancer not diagnosed until after her death. The report stated that this occurred because her referral to secondary care was delayed, and her risk factors were not fully recognised when triaged by secondary care.

She was referred in April 2020 for an ultrasound scan having reported symptoms of recurrent very heavy vaginal bleeding. Her BMI was high. The ultrasound was only able to report a partial view and it was recommended she be referred to a gynaecologist for review; this did not occur. In November 2020 it was identified that a referral had not been made and a letter for referral was written marked urgent. However, the e-referral that accompanied the letter was marked routine and was limited in detail. Therefore, the hospital triaged the treatment as routine. The GP practice was unaware that the patient was not seen urgently. In March 2021, she attended the local emergency department due to her pain and heavy vaginal bleeding. She was discharged with painkillers and was due for a follow up call and scan; this did not happen. Subsequently there was a telephone consultation with a consultant gynaecologist who referred her for a transvaginal ultrasound. The appointment was not face to face due to Covid, so she was not examined, and her BMI was not recognised. She re-attended the emergency department 16 days later, was operated on and found to have a tube/ovarian mass and extensive peritonitis. She died of septic shock."

We know that there are challenges in supporting effective communication between healthcare professionals and patients during clinical care and that these can contribute to patient safety healthcare inequalities. In particular, patients for whom English is not their first language are at a greater risk of harm from medication errors and misunderstandings (Wade et al, 2022 (https://www.bmj.com/content/376/bmj-2021-067090)). We want to enhance our communications with patients including via text, and reduce inequalities by having access to real-time interpreting and translation services in primary care (https://www.england.nhs.uk/primary-care/primary-care-commissioning/interpreting/), and especially within text messaging services for patients.

We want primary care to have information systems that automatically flag patient safety issues such as missed patient referral follow-ups, safeguarding, diagnoses and medication issues, and accredited IT tools that support reliable referral and follow-up. Plus we want IT to consistently support clinical decisions in primary care, by digitally embedding differential diagnosis decision guidance and safety netting advice.

We know that other industries such as nuclear power have a structured approach to safety management via the use of safety management systems (SMSs). (https://www.hssib.org.uk/patient-safety-investigations/safety-management-systems/) Such systems take a proactive and integrated approach that combines hazard identification and risk management, monitoring of safety performance and the impact of interventions, training and education and promotion of safety. We will explore the application of the SMS approach to primary care patient safety.

We want accredited IT products to support reliable referrals and follow-ups and enable digital inclusion, which involves ensuring highly usable and accessible digital tools are available for patients and the workforce. Commissioners and primary care providers can buy digital tools and systems from approved suppliers through the Digital Care Services (DCS) catalogue (https://digital.nhs.uk/services/digital-care-services-catalogue). These are suppliers that, through the catalogue agreement, meet the required technology and data, assurance and service management standards. We want suppliers to evidence that they meet NHS standards on usability and accessibility, and to co-design products around the user needs.

We want primary care to also take steps to address the barriers to digital health that some groups may face. The inclusive digital healthcare framework (https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/) can be used when initiating, developing and updating services to ensure that digital approaches and technologies are designed and implemented inclusively, and are complementary to non-digital support. We want ICBs to provide evidenced based support to providers to implement new technology to optimise realisation of benefits for patients and the workforce.

Opportunities

The delivery plan for recovering access to primary care (2023) (https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/) is the key operational approach to improving services in primary care. This has a focus on changing and improving access and improving staffing by growing the practice multidisciplinary team. Implementation of the Modern general practice model (https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/modern-general-practice-model/) is supported by the general practice improvement programme including online resources and how to best practice guides (https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/resources/) for improvement. Achieving the delivery plan underpins the ability of practices to mature workflows to improve safer, fairer assessment of care needs and improve safety culture with more supportive leadership and teamwork.

Improved staffing will include the use of roles such as care navigators (https://www.hee.nhs.uk/our-work/care-navigation) and other members of multidisciplinary team who can improve continuity of care and enabled improved patient access to health services. We know that leadership and teamwork are important aspects of safety culture and so there are opportunities to take ideas and learning from the research in How to build effective teams in general practice (2020) (https://www.kingsfund.org.uk/publications/effective-teams-general-practice?gclid=Cj0KCQiA09eQBhCxARIsAAYRiynJeYsm6dF2hOPLBZ49JvefqGkuopWGh5Hv8-OQw2s0LaSYnejgGJAaArixEALw_wcB).

NHS England's primary care hub on FutureNHS (https://future.nhs.uk/connect.ti/PrimaryCareHub) now includes GP career support information and resources for primary care employers, managers and leaders on effectively managing teams and dedicated pharmacy and dentistry spaces.

We have worked with a number of providers rated 'good' and 'outstanding' for safety by the CQC, including primary care providers, to understand how they have moved from a Safety-I to a Safety II approach. Safety I focuses on the rare examples of things that have gone wrong, for example incidents, while Safety-II encompasses learning from why things routinely go right in healthcare (Hollnagel et al, 2015 (https://www.researchgate.net/publication/282441875_From_Safety-I_to_Safety-II_A_White_Paper)). Primary care organisations can use ideas from Safety culture: learning from best practice (2022) (https://www.england.nhs.uk/publication/safety-culture-learning-from-best-practice/) which describes innovations that have helped organisations to improve and Improving patient safety culture – a practical guide (2023) (https://www.england.nhs.uk/patient-safety/patient-safety-culture/improving-patient-safety-culture-a-practical-guide/) which advises how to improve the patient safety culture in relation to teamwork, communication, just culture, psychological safety, promoting diversity, inclusive behaviours and civility.

Community pharmacy and dental services have both developed specific groups to support patient safety improvements sharing ideas and innovations: the Community Pharmacy Patient Safety Group (https://pharmacysafety.org/) and Project Sphere (https://www.england.nhs.uk/primary-care/dentistry/leading-the-change/patient-safety/).

We know that improving the interface between primary and secondary care is a key part of patient safety. So relevant recommendations from The Academy of Medical Royal Colleges report: general practice and secondary care: working better together (https://www.aomrc.org.uk/wp-content/uploads/2023/05/GPSC_Working_better_together_0323.pdf) can be implemented in ICBs and practices. The report includes over 50 examples of where local collaboration across the system has also reduced workload in clinical settings.

Case study 1: South West Innovation Labs

The Innovation Labs launched a Safe and **GREAT** day in primary and community care in 2022. This enabled engagement via place and neighbourhood as people came together to understand the challenges of complexity and use a human centred design methodology. This acknowledged that "What matters to you, matters to us!" to create a 'team of teams' approach across primary and community care services.

They concluded that all change and transformation work is predicated on creating headspace for teams to come together and design something different. It is a never ending journey that requires specific skills and energised collaborative leadership. The information has been provided with the intention to support other communities in their efforts to make their day safer and more enjoyable.

Innovation Labs – NHS England South West – Improvement Capability Building – FutureNHS Collaboration Platform (https://future.nhs.uk/SWestImprovementCapability/view?objectID=34176560)

ICBs are now responsible for providing general practice digital services. Currently, EMIS (https://www.emishealth.com/) and TPP (SystmOne) (https://tpp-uk.com/products/) automatically flag follow-ups to improve patient safety, and the Ardens (https://www.ardens.org.uk/) system integrates DNA (did not attend) reviews (https://support.ardens.org.uk/support/solutions/articles/31000154482-dna-review-follow-up) and 2-week cancer referrals and safety netting cancer 2-week wait referrals and safety netting (https://support.ardens.org.uk/support/solutions/articles/31000146029-cancer-2ww-referrals-safety-netting) templates.

Digital clinical safety statutory duties, accountabilities and responsibilities for providers, ICBs and regions are detailed in the GPIT operating model (https://www.england.nhs.uk/digitaltechnology/digital-primary-care/gp-digital-services-operating-model-21-23/), the delivery of quality functions in ICSs (May 2024) (https://future.nhs.uk/ICSQualityHub/view?objectId=122926341) and the digital clinical safety strategy (2021) (https://www.nhsx.nhs.uk/key-tools-and-info/digital-clinical-safety-strategy/). Digital suppliers are required to ensure clinical safety documents showing compliance with clinical risk management standard DCB0129 (https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb0129-clinical-risk-management-its-application-in-the-manufacture-of-health-it-systems) are completed, regularly reviewed, updated and shared with the ICBs as part of their legal duties, similarly ICBs are required to complete and regularly review clinical safety documents showing compliance with DCB0160. ICBs should involve general practice staff and patient groups in the digital tool procurement processes and provide practical support to general practice to implement digital tools effectively and safely utilising evidence based best practice guidance. ICBs should facilitate sharing of best practice between general practices utilising the same software.

Following COVID-19 from October 2021, new digital and online services requirements guidance (https://www.england.nhs.uk/gp/investment/gp-contract/digital-requirements-guidance/new-digital-and-online-services-requirements-guidance-for-gp-practices/) was implemented for GP practices to provide increased choice and flexibility for patients in how they access care, and to also provide benefits to practices in managing and prioritising their workload. All practices must now offer and promote to patients the ability to access and use an 'online consultation tool'. Many practices have found that using an online consultation tool can deliver significant benefits for both patients and the practice. To support digital safety there is training on the essentials of digital clinical safety (https://www.e-lfh.org.uk/programmes/essentials-of-digital-clinical-safety/), which all primary care staff can access for free. ICBs must identify clinical safety officers who support general practice to implement digital tools safely. Clinical safety officers engage with general practice to build understanding of the clinical safety case and good practice, including enabling staff to raise safety concerns, discuss and share improvements as part of a dynamic approach to continual improvement of patient safety.

Two academic groups have together developed a toolkit for building equitable primary care (2023) (https://www.qmul.ac.uk/ceg/media/ceg/documents/Final_HealthInequalitiesReport_Cambridge_Reduced.pdf) for local decision-makers. Training resources targeted at improving inequalities in primary care are also available via Fairhealth (https://www.fairhealth.org.uk/) modules.

Tools such as the VCSE inclusion health audit tool (https://www.inclusion-health.org/) and inclusion health tool for primary care networks (https://www.inclusion-health.org/pcn/?utm_source=The%20King%27s%20Fund%20newsletters%20%28main%20account%29&utm_medium=email&utm_campaign=12982208_NEWSL_HWB_2022-02-21&dm_i=21A8,7Q94W,FLWQE8,VJBO9,1) can help primary care organisations to understand how effectively they are engaging with their service users and community partners. The SPOTLIGHT tool (https://analytics.phe.gov.uk/apps/spotlight/) and the health inequalities dashboard (https://analytics.phe.gov.uk/apps/health-inequalities-dashboard/) can also be used to build an inclusion health data profile.

Implementing the NHS Staff Survey (https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fprimarycarebulletin.cmail20.com%2Ft%2Fd-l-vfxlk-ttjhetihy-e%2F&data=05%7C01%7Chester.wain%40nhs.net%7C15abc2ab47434ff89f6808db7968857b%7C37c354b285b047f5b22207b48d774ee3%7C0%7C1%7C638237262057455548%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=NGX6W%2FFigRBvsTCOGFVtmQKeZgBB8gnz1jfHO8oBrvk%3D&reserved=0) in primary care will provide standardised, comparable, actionable staff experience data that can be used to understand challenges and target these for improvement. The first NHS General Practice Staff Survey (GPSS) was piloted in October 2023, with a second pilot in October 2024. This is again voluntary, with the majority of ICBs committed to providing support for participation. The long term aim is for the staff survey to form part of the annual cycle across the whole of primary care . Before then, community pharmacy, optometry and dental service staff feedback should also be encouraged via local staff surveys and used to enable improvements.

Freedom to Speak Up (FTSU) is another mechanism that gives staff a voice that counts and ICBs should ensure primary care staff have access (https://www.england.nhs.uk/ourwork/freedom-to-speak-up/integrated-care-boards-integrated-care-systems-and-freedom-to-speak-up/) to FTSU guardians who are independent to the provider practice.

Looking after staff is a key component of providing safe patient care. Primary care staff and teams can access the 'looking after you' (https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fprimarycarebulletin.cmail19.com%2Ft%2Fd-l-vjtituk-ttjhetihy-yd%2F&data=05%7C01%7Chester.wain%40nhs.net%7Cc64bb44acff0446a7e6608db99d0b908%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638272893974063036%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=psegxSuWlC4AfunvNFyDz3v2H71FaimXYbqAktwn7eA%3D&reserved=0) suite of health and wellbeing offers, and the practitioner health service (https://www.practitionerhealth.nhs.uk/) is a free, confidential NHS primary care mental health and addiction service with expertise in treating health and care professionals. Everyone in the primary care team can self-refer into this service. Continuous quality improvement focused on workforce and wellbeing is an income protected indicator within the Quality and outcomes framework (QOF) guidance for 2024/25 (https://www.england.nhs.uk/publication/quality-and-outcomes-framework-guidance-for-2024-25/).

Local commitments

1. General practice with ICBs support to give staff the opportunity to complete the NHS general practice Staff Survey (information on Future NHS (https://future.nhs.uk/connect.ti/StaffExperienceandEngagement/view?objectID=44865008)), and general practice to act on the published survey findings to improve safety culture and staff experience.

2. Community pharmacy, optometry and dental service providers to support staff to complete local staff surveys where available and to act on the survey findings to improve safety culture and staff experience.

3. All staff and students (clinical and non-clinical) in primary care to have access to complete the free online NHS patient safety syllabus training (https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/) levels 1 and 2 (with a primary care-specific module). This training includes information on safety culture, human factors and ergonomics, just culture and incidents. It can be accessed by those without an nhs.net address and takes around 1 hour to complete.

4. ICBs should ensure primary care staff have access (https://www.england.nhs.uk/ourwork/freedom-to-speak-up/integrated-care-boards-integrated-care-systems-and-freedom-to-speak-up/) to FTSU guardians who are independent to the provider practice.

5. ICBs to identify digital clinical safety officers and provide effective digital and implementation support and training to primary care to enable benefit realisation, as detailed in the GPIT operating model (https://www.england.nhs.uk/digitaltechnology/digital-primary-care/gp-digital-services-operating-model-21-23/), the Delivery of quality functions in ICSs (May 2024) (https://future.nhs.uk/ICSQualityHub/view?objectId=122926341) and the Digital clinical safety strategy (2021) (https://www.nhsx.nhs.uk/key-tools-and-info/digital-clinical-safety-strategy/).

6. ICBs to procure safe digital products for general practice that meet quality assured standards (including DCB0129 (https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb0129-clinical-risk-management-its-application-in-the-manufacture-of-health-it-systems)) and to ensure they are highly usable and accessible for patients and the workforce.

National commitments

The National Patient Safety team, working with relevant NHS England teams and partners, will:

1. Co-design primary care examples of just culture, thus improving the response to safety events and reducing any fear of safety event recording.

2. Promote a systems approach (and not an individual approach) as the appropriate response to patient safety incidents in primary care (working with regulatory bodies such as CQC, GMC, GDC, GOC, GPhC, NMC and PAG and other partners such as HSSIB and NHSR).

3. Review the data from the new NHS general practice Staff Survey and understand the responses to the patient safety questions to identify areas for patient safety improvement.

4. Promote areas identified as priorities for digital decision support and support the continuation of work on digital interoperability for primary care settings.

5. Oversee the progress and impact of safety culture actions and the person-centred safety improvement plan in relation to primary care.

6. Produce a patient safety healthcare inequalities reduction handbook for primary care that supports individuals to make effective changes.

7. Develop the Learn From Patient Safety Events (LFPSE) service to record protected characteristics of those involved in patient safety events to identify improvements to reduce healthcare inequalities in primary care.

8. Provide ICBs with best practice examples of FTSU guardian models within primary care.

Insight

Patient safety insight is about improving the understanding of safety across the whole system by drawing intelligence from multiple sources of patient safety information. Central to learning from safety events in primary care are the new Learn From Patient Safety Events (LFPSE) service (https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/learn-from-patient-safety-events-service/) and the Patient Safety Incident Response Framework (PSIRF) (https://www.england.nhs.uk/patient-safety/incident-response-framework/).

The LFPSE service replaces the National Reporting and Learning System (NRLS) which closed in June 2024 and makes it possible for staff across all healthcare settings, including primary care, to record safety events. Around three-quarters of reporting to its predecessor (and StEIS) was from hospitals. Community pharmacy contractors had been required to record incidents via the national incident system since 2005, and so are now required to do so using the LFPSE service.

The PSIRF was launched in acute, ambulance, mental health and community healthcare providers in 2022. It sets out the approach for responding to patient safety events (or incidents) for the purpose of learning and improving patient safety. This approach is flexible and adapts as organisations learn and improve, so they explore patient safety incidents relevant to their context and the populations they serve. The PSIRF standards (2024) (https://www.england.nhs.uk/long-read/patient-safety-incident-response-standards/) set out the expectations for system-wide responses, such that cases like Serena's (see above) will benefit from a cross-organisational approach to the sharing of learning and embedding change.

Ambitions

We want improved patient outcomes and experience in primary care – reduced patient harm, fewer complaints and less litigation, staff who are less stressed, a better understanding of pressures and improved efficiency. This will be supported by structures and processes (LFPSE and PSIRF) that enable an appropriate response with learning, sharing of learning and improvement.

We want a single, simple patient safety event recording form and process, with improved quality of incident (patient safety event), near miss (sometimes called good catches), good practice events and risk recording. Staff and patients need to be able to easily access the form and be given clear instructions and information on its completion. Primary care needs targeted communications to raise awareness of learning opportunities from recording events.

We want to ensure that patients in primary care are not harmed by known patient safety issues identified in national patient safety alerts (https://www.england.nhs.uk/patient-safety/patient-safety-alerts/).

Case study 2: Our Health Partnership (https://ourhealthpartnership.com/) sharing medication safety learning

Our Health Partnership (OHP) brings together 30 practices running across 39 surgeries in the Midlands and Shropshire, and is one of England's largest GP practices. To improve patient safety, the OHP practices and PCNs share all complaints and learning events. All staff types are involved in the reporting process and the multidisciplinary OHP Quality & Support team review reports, identify themes and share learning across the organisation. If required extra support can be provided for this. This supported learning and embedded safety culture involves all organisational layers, creates consistency of insight and maximises spread of improvement.

Case study – Our Health Partnership MSO report 2023 – NHS Patient Safety – FutureNHS Collaboration Platform (https://future.nhs.uk/NHSps/view?objectId=210271941)

While there is no intention to lift and shift PSIRF directly from secondary care into primary care, we want to implement its concepts of **proportionate, flexible and contextual** into the primary care response to incidents, dependent on local configurations.

Opportunities

The LFPSE service enables a more dynamic interaction with patient safety events information as the form can be accessed via an app and the system will use machine learning to identify emerging issues more quickly.

Local recording of patient safety events via LFPSE (https://www.england.nhs.uk/patient-safety/learn-from-patient-safety-events-service/) enables local learning, sharing of learning and of the incident response. At a national level, recording will identify new or under-recognised patient safety issues in primary care and act to prevent future harm to patients via alerts.

How to access the LFPSE service in primary care

We have designed a primary care-specific LFPSE information (https://www.england.nhs.uk/patient-safety/learn-from-patient-safety-events-service/primary-care-information/) site that explains how to log onto the system and record an event, and user guides are available at the bottom of each page of the LFPSE webform (https://record.learn-from-patient-safety-events.nhs.uk/).

Primary care organisations that already have dedicated local incident recording software will need to check their system is compliant with and connected to LFPSE. The list of compliant suppliers is available via: LFPSE-compliant Local Risk Management System (LRMS) suppliers (https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/learn-from-patient-safety-events-service/lrms-suppliers/).

If your system is compliant and connected to LFPSE, your records will be automatically shared with the national system and you do not need to take any further action. If your system is not LFPSE compatible, please ask your supplier about their plans in this regard. There is information for them on the link above, or providers can contact england.patientsafetyhelpdesk@nhs.net (mailto:england.patientsafetyhelpdesk@nhs.net) for further information and next steps.

LFPSE will soon be enhanced with the functionality to use the data to inform Patient Safety Incident Response (PSIRF) planning.

What to record in LFPSE is outlined at CQC GP Mythbuster 24: recording patient safety events (https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-24-recording-patient-safety-events-learn-patient-safety-events), alongside details on significant event analysis/audit (SEA) (https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-3-significant-event-analysis-sea) learning and sharing. ICBs have responsibility for implementing effective clinical and care professional leadership (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0664-ics-clinical-and-care-professional-leadership.pdf), which includes nurturing a culture that systematically embraces shared learning.

LFPSE is developing a patient, service user, family and carer interface (https://www.england.nhs.uk/long-read/the-learn-from-patient-safety-events-lfpse-service/) to record patient safety events and is looking into how to record of incidents of violence against staff and patients.

The implementation of the actions identified in national patient safety alerts (https://www.england.nhs.uk/patient-safety/patient-safety-alerts/) should be part of all primary care governance review processes. National action short of issuing a national alert is also taken where review of primary care patient safety incident records indicates a need for this; see patient safety review and response (https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/how-we-acted-on-patient-safety-issues-you-recorded/clinical-specialty/#PC).

Case study 3: National Patient Safety Alert – Shortage of GLP-1 receptor agonists

Recording of primary care patient safety incidents on the national system identified a shortage of glucagon-like peptide-1 receptor agonists (https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103245). Supply issues stemmed from an increase in demand for these products for licensed and off-label indications. An patient safety alert was issued requesting a stop to their off-label use.

The updated pharmacy incident reporting guide (https://www.england.nhs.uk/long-read/incident-reporting-system/) explains that pharmacies must have a patient safety incident log for all incidents which should be recorded via LFPSE and they must maintain a record of errors identified as part of the checking process (near misses) for internal review and learning.

Case study 4: Medicines incidents and learning points

Surrey Heartlands ICS (https://www.surreyheartlands.org/) has developed a number of ways of targeting learning from incidents. Medicines safety incident reports from GP practices are collated each quarter and a summary of the issues and learning points is shared. These include examples of similar patient names resulting in them both receiving the wrong medication and ensuring that patients are as informed as possible, and so more able to spot potential errors in their own medications.

Case study – Surrey Heartlands Q2 2023-24 LFPSE report summary – NHS Patient Safety – FutureNHS Collaboration Platform (https://future.nhs.uk/NHSps/view?objectId=210272037)

General practice will be the first area of primary care to start PSIRF implementation from 2024. PSRIF pilot sites will be supported by the 15 Health Innovation Networks (HIN) who have been commissioned support to work directly with general practice via their Patient Safety Collaboratives, to test the application of PSIRF principles and develop case studies for wider sharing.

Case study 5: PSIRF in Middlewood Partnership

Middlewood Partnership (https://middlewoodpartnership.co.uk/) is a group of 4 GP practices that together provide safe and responsive services to their 34,000 patients across Bollington, Disley and Poynton. The partnership is one of the first primary care adopters of PSIRF and one of its partners, Dr Paul Bowen, has recorded a podcast describing the benefits of PSIRF in general practice (https://www.youtube.com/watch?v=g-JIsnfRTjU) as well as the challenges in implementing this approach.

Medical examiners (https://www.england.nhs.uk/patient-safety/patient-safety-insight/national-medical-examiner-system/), supported by medical examiner officers, provide independent scrutiny of deaths that are not investigated by a coroner, and give bereaved people the chance to ask questions and raise concerns. Based in acute trusts, they have been working with GP practices (https://www.england.nhs.uk/patient-safety/patient-safety-insight/national-medical-examiner-system/non-acute-nhs-trusts-extending-medical-examiner-scrutiny-to-non-coronial-deaths-in-the-community/) to help them prepare for all deaths to be reviewed by medical examiners. Regulations (https://www.gov.uk/government/collections/death-certification-reform-and-the-introduction-of-medical-examiners) introducing changes to the death certification process were laid before Parliament on 15 April 2024 and will come into force on 9 September 2024. The Royal College of Pathologists published a Good practice paper (https://www.rcpath.org/static/d1777754-a478-40b9-9d3cca47df96937b/Good-Practice-Series-12-Escalating-thematic-issues.pdf) encouraging links between medical examiner offices, healthcare providers, ICBs and regions to maximise the opportunities for learning to improve care and patient safety.

Case study 6: GP and medical examiners working together

This podcast (https://soundcloud.com/nhsengland/gps-and-medical-examiners-working-together) explains how partnership working between GPs and medical examiners improves the experience of bereaved people, and explores the advantages for GPs.

Local commitments

1. ICB quality groups/committees and patient safety specialists to develop mechanisms that support the adoption of LFPSE and PSIRF in primary care, sharing of insight and learning, and improve communication across systems for primary care. ICBs should explore sharing using existing structures such as buddying/peer systems for practices/organisations, and PCN-based patient safety groups.

LFPSE service:

2. All ICBs, general practices, community pharmacies, optometry providers and dental providers to register for an administrator account (https://record.learn-from-patient-safety-events.nhs.uk/) with LFPSE or to connect their local risk management system (https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fpatient-safety%2Fpatient-safety-insight%2Flearning-from-patient-safety-events%2Flearn-from-patient-safety-events-service%2Flrms-suppliers%2F&data=05%7C02%7Chester.wain%40nhs.net%7C7ccd4dc32ca04c882aea08dc3e943b8a%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638454053567915706%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=TGqvUteH7CHF4m2KAnke8af5fV7VF3CVPCXzoOnNhdg%3D&reserved=0) to LFPSE to ensure that patient safety events are recorded on the national system. This will enable learning that supports local and national patient safety improvement.

3. All ICBs, general practices, community pharmacies, optometry providers and dental providers to provide user feedback (mailto:england.patientsafetyhelpdesk@nhs.net) to LFPSE on how to improve the interface.

4. Primary care providers to encourage individual practitioners to register (https://record.learn-from-patient-safety-events.nhs.uk/) with LFPSE so that they can record and access their records via the LFPSE data access app (https://access-data.learn-from-patient-safety-events.nhs.uk/) for use in appraisal and revalidation.

PSIRF:

6. General practice, with support from ICBs, to start implementing the Patient safety incident response framework (PSIRF) (https://www.england.nhs.uk/patient-safety/incident-response-framework/) that is proportionate, flexible and contextual. This could be at place or via GP federations or PCNs. Community pharmacy, optometry and dental service providers should also start to implement PSIRF where they feel confident to do so.

National commitments

The National Patient Safety team, working with relevant NHS England teams and partners, will:

1. Continue to explore opportunities to enhance national and local learning in primary care by identifying how the LFPSE service can best record and share data, and learn from patients, service users, families and carers who have experienced a patient safety event.

2. Continue to work with patients, service users, families and carers to understand their needs and what further resources can help support the future roll-out, adoption, and user-friendliness of a patient-facing LFPSE service.

3. Provide guidance and examples of how PSIRF principles can be applied in primary care.

4. Develop a patient safety primary care communications plan that identifies the optimum pathways for patient safety information dissemination to primary care; for example, via national primary care commissioning broadcast cascade, or ICS or regional communication.

5. Continue working with Project Sphere (https://www.england.nhs.uk/primary-care/dentistry/leading-the-change/patient-safety/) to develop opportunities to share patient safety events learning, along the lines of the forum provided by the Community Pharmacy Patient Safety Group (CPPSG) (https://pharmacysafety.org/) for open sharing of things that go wrong in community pharmacy.

6. Explore incentivising patient safety (such as with leadership, training or protected time) through national or local schemes and contractual levers.

Case study 7: Community Pharmacy Patient Safety Group (CPPSG)

The community pharmacy patient safety group works to enhance patient safety culture and practice across the community pharmacy network in Great Britain. Their terms of reference are included for consideration by other services.

Case study – Community Pharmacy Patient Safety Group ToR – June 2021 FINAL – NHS Patient Safety – FutureNHS Collaboration Platform (https://future.nhs.uk/NHSps/view?objectId=210271973)

Involvement

Patient safety involves everyone in all aspects of healthcare: patients, service users, families, carers, staff and students. The NHS Patient Safety Strategy emphasises the important role of patients, service users, their families and carers, and other lay people in providing safer care via the Framework for involving patients in patient safety (https://www.england.nhs.uk/publication/framework-for-involving-patients-in-patient-safety/). This framework describes how organisations should support people to be directly involved in their own safety, or the safety of person they care for and how they should recruit lay people to patient safety partner (PSP) roles that in partnership with staff can influence and improve the governance and leadership of safety within an NHS organisation, including primary care.

General practice has had patient involvement via patient participation groups (PPGs) for a number of decades, and as a contractual requirement since 2015. These groups are usually made up of volunteer patients, the practice manager and one or more of the GPs from a practice who work together to promote the patient voice.

Patient safety specialist (PSSs) (https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2FPSS) are nominated staff who lead safety improvement. There are around 800 PSSs embedded in acute, ambulance, mental health, community healthcare providers, ICBs, arm's length bodies and a few primary care providers.

The Working in partnership with people and communities: statutory guidance (2022) (https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/) supports health and care systems to build positive and enduring partnerships with their communities to improve services and outcomes for everyone.

Ambitions

We want more patients, service users, carers and families to be more involved in the co-production of patient safety improvements in primary care, and to encourage further diversity in the patient voice that is heard.

We want to enable more staff to become patient safety leads in primary care and are looking to develop a recognised patient safety lead role in primary care organisations that are large enough to support this.

We want more staff and students to complete the free online NHS patient safety syllabus training (https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/) levels 1 and 2, introduced in 2022, and where possible to have protected training time to do so. This training better equips them to learn from what goes well as well as how to respond appropriately to things that go wrong. The Improvement Academy (https://qitraining.improvementacademy.org/) also provides free online access to bronze entry-level quality improvement training.

Case study 8: NHS Dorset

NHS Dorset launched its strategy to improve patient safety in primary care in November 2021 following the recruitment of a GP lead for patient safety to work with the quality team. A project group was established to include primary care in the ICS approach to delivering the NHS Patient Safety Strategy, initially working with general practice. The local strategy evolves as general practice makes progress and priorities emerge. Recent updates can be requested from patientsafety@nhsdorset.nhs.uk (mailto:patientsafety@nhsdorset.nhs.uk).

Case study – Dorset Strategy for Patient Safety in General Practice v8 – NHS Patient Safety – FutureNHS Collaboration Platform (https://future.nhs.uk/NHSps/view?objectId=210272005)

Opportunities

The Framework for involving patients in patient safety (https://www.england.nhs.uk/publication/framework-for-involving-patients-in-patient-safety/) provides guidance, role descriptions and tools to enable providers, including those in primary care, to co-produce patient safety improvements with their patients, service users, carers and families. Diverse patient involvement ensures that the voice of all communities is heard, especially those experiencing health inequalities.

We recognise implementation of this framework across primary care will take time, particularly in community pharmacy, optometry and dental services which are somewhat behind general practice in terms of their involvement of patients and lay people in their safety governance systems.

PPGs are well placed to further develop those with an interest in patient safety to become PSPs. The national GP Patient Survey (https://gp-patient.co.uk/), ongoing since 2007, also provides a wealth of information from patients that can be used more in safety and service improvements.

For general practice, involving patients in their own safety can start in the waiting room by showing patient safety messages on screen including the film simple steps to keep you safe during your hospital stay (https://www.england.nhs.uk/patient-safety/framework-for-involving-patients-in-patient-safety/simple-steps-to-keep-you-safe-during-your-hospital-stay-webpage-for-patients/) (which should be viewed before patients go to hospital).

PSSs are already embedded in ICBs and they can support the development of primary care patient safety leads. These leads can also seek advice from their ICB's medication safety officer (MSO), as recommended by the Clinical Negligence Scheme for General Practice overview report (2022) (https://resolution.nhs.uk/wp-content/uploads/2022/08/3523-CNSGP-Report-DV5-SINGLE-Access-1.pdf).

Local commitments

1. GP, dental, pharmacy and optometry practices, place or PCNs start to identify patient safety leads and enable them to complete the free online NHS patient safety syllabus training levels 1 and 2 (https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/) (with primary care module).

2. GP, dental, pharmacy and optometry practices or PCNs start to identify two or more lay Patient safety partners (PSPs) in line with the Framework for involving patients in patient safety (https://www.england.nhs.uk/publication/framework-for-involving-patients-in-patient-safety/), and enable them to complete the free online NHS patient safety syllabus training levels 1 and 2 (https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/) (with primary care module).

3. General practices to add patient safety to their PPG agendas.

4. ICB Patient safety specialists (PSSs) to provide guidance and support for the local implementation of patient safety leads and PSPs.

National commitments

The National Patient Safety team, working with relevant NHS England teams and partners, will:

1. Co-develop flexible and contextual guidance for patient safety partner recruitment across primary care.

2. Use the Framework for involving patients in patient safety (https://www.england.nhs.uk/publication/framework-for-involving-patients-in-patient-safety/) to develop patient involvement in community pharmacy (working with Community Pharmacy England and local pharmaceutical committees), dental (working with Project Sphere and local dental committees) and optometry services (working with local optometry committees).

3. Provide clear guidance to ICB PSSs on how they should prioritise cross-system support for primary care.

4. Review the efficacy of different ICB models for PSSs dedicated to primary care, for example a general practice PSS, or an area specific PSS located at PCN level. This review will generate examples of good practice that will be shared with ICBs.

5. Co-develop flexible and contextual guidance for the development of patient safety leads in primary care at, as a minimum, PCN level, and link them to PSS networks for support.

6. Review opportunities to add patient safety training to the continued professional development (CPD) requirements for community pharmacy, optometry and dental services via GPhC, GOC, GDC and NMC.

7. Promote user centred co-design of digital products to ensure they are highly usable and accessible for patients and staff.

Improvement

Our approach aligns with that of NHS IMPACT (improving patient care together) (https://www.england.nhs.uk/nhsimpact/): by creating the right conditions for continuous improvement and high performance, primary care can deliver safer care and better outcomes for patients and communities. For example, Avery et al (2020) (https://qualitysafety.bmj.com/content/30/12/961) identified 3 main patient safety themes in general practice:

- diagnosis
- medication
- referral

Diagnostic errors (wrong, missed or delayed) have long been recognised as a source of severe harm and death (Newman-Toker et al, 2022 (https://pubmed.ncbi.nlm.nih.gov/32412440/), Hogan et al, 2015 (https://www.bmj.com/content/351/bmj.h3239/)). Diagnostic errors disproportionately affect people from protected groups and those affected by health inequalities, with 'diagnostic overshadowing' in people with learning disabilities a particular concern (White et al, 2022 (https://www.kcl.ac.uk/ioppn/assets/fans-dept/leder-2022-v2.0.pdf)).

There are no known quick fixes for diagnostic errors, although UK studies (Avery et al, 2020 (https://qualitysafety.bmj.com/content/30/12/961), Cheraghi-Sohi et al, 2021 (https://qualitysafety.bmj.com/content/30/12/977)) suggest most can be reduced with interventions that ensure diagnostic opportunities are taken, not missed, but these have rarely been operationalised in clinical practice.

Concerns have been voiced that remote encounters are more susceptible to diagnostic or other errors. In 2023, Payne et al (https://qualitysafety.bmj.com/content/early/2023/11/26/bmjqs-2023-016674), reviewed patient safety in remote primary care encounters such as by telephone and video and identified that safety incidents (involving death or serious harm) were rare, though do happen. They sought to understand why safety and near-miss incidents rarely occurred and why they did not occur more often. The study concluded that frontline staff used creativity and judgement to help make care safer (Safety II) and that this should be recognised and supported.

Many GP practices have found that using digital tools such as an online consultation tool (https://www.england.nhs.uk/gp/investment/gp-contract/digital-requirements-guidance/new-digital-and-online-services-requirements-guidance-for-gp-practices/) can deliver significant benefits for both patients and the practice. ICBs should support training of general practice staff in new ways of working such as triage and remote consulting building on existing guidance and resources (https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/resources/), alongside digital skills training and training in the use of their digital systems.

Diagnosis: Patient B's story

Patient B had a history of breast cancer and 2 years after being discharged from the breast cancer service he began to have back pain. Initially the pain was so severe that patient B visited his local emergency department (ED). He was discharged from the ED with pain relief and was advised to contact his GP practice.

A month later, he telephoned his GP practice and saw his named GP. The GP referred him to the practice's physiotherapist and requested a blood test. He saw the physiotherapist, who gave him advice about exercises to relieve the back pain. The exercises were not effective and over the following 8 months patient B saw 2 out-of-hours GPs and 6 practice GPs, a nurse and a physiotherapist at the practice.

Patient B also had consultations with healthcare professionals during this time for other conditions unrelated to his back pain. When he saw a GP at end of the 8-month period, the GP found a lump on his spine and advised patient B to go to the local ED. At the ED, patient B had a computerised tomography (CT) scan. A lump on his spine was confirmed and later diagnosed as metastatic breast cancer (that is, breast cancer that had spread to his spine).

The Health Services Safety Investigations Body (HSSIB) investigated patient B's care and reported its findings: Continuity of care: delayed diagnosis in GP practices (https://www.hssib.org.uk/patient-safety-investigations/continuity-of-care-delayed-diagnosis-in-gp-practices/#the-reference-event).

Since November 2021, working with primary care and care homes our medication safety improvement programme (https://www.england.nhs.uk/patient-safety/patient-safety-improvement-programmes/#MedSIP) is estimated to have saved 414 lives and prevented 2,569 cases of moderate harm by reducing the prescribing of high-strength opioids. By engaging with 10,537 care homes to improve management of patient deterioration (https://www.england.nhs.uk/patient-safety/patient-safety-improvement-programmes/#ManDet) we have reduced emergency general practice consultations, as well as 999 calls and hospital attendances.

Medication: Patient J's story

Taken from the Coroner's Prevention of future deaths report (https://www.judiciary.uk/prevention-of-future-death-reports/jacqueline-campbell-prevention-of-future-deaths-report/)

"Patient J died at the age of 56 in June 2022 at her home address. She had had chronic backpain for more than 20 years that was difficult to manage. She was prescribed large doses of gabapentin, tramadol and amitriptyline to relieve her pain. She was also prescribed fentanyl patches and oral diazepam. The police and paramedics attending the scene described finding "hundreds" of packets of medications, some opened, some unopened. She probably inadvertently overdosed on tramadol and that, in combination with the other medicines, all possessing the ability to depress the central nervous system, had the synergistic effect of causing respiratory depression and death."

In the report the coroner identified that polypharmacy including gabapentinoids and opiates represents a severe safety risk in patients with a iatrogenic drug dependency.

Referral incidents occur when a clinician has decided that a referral was needed, but there was a delay in the referral being made such that the patient was harmed as a result. The most common occurrences are due to: the referral from primary care was not made when indicated; communication about the patient was not sent from secondary to primary care; or the incorrect test was ordered (Avery et al, 2020 (https://qualitysafety.bmj.com/content/30/12/961)). Referral incidents are well documented and have also been acknowledged in Cooper et al's study on Nature of blame in patient safety incident reports (https://pubmed.ncbi.nlm.nih.gov/28893816/).

Ambitions

We want to enable patient safety improvements in primary care focussed on the 3 patient safety themes (Avery et al, 2020 (https://qualitysafety.bmj.com/content/30/12/961)), supporting teams to co-develop change with patients and families that prevents harm. We also subsequently want to review patient safety themes for improvement in community pharmacy, optometry services and dental services and then to develop and test novel approaches.

We now have a better understanding of the scale and nature of diagnostic safety, so we need to start to identify and test interventions. We want to identify medical conditions and patient groups that we know are more at risk of harm, and who are also more amenable to successful treatment, such as patients with undiagnosed HIV. Once identified we want to co-design best treatment options that provide optimal care pathways such as RightCare scenarios (https://gettingitrightfirsttime.co.uk/academy-resources/population-health/), which include person-centred stories, and highlights the role of primary care in early diagnosis, timely referral and supporting patients to manage their condition.

We want general practices to deliver continuity of care, the implementation of which will be determined by the internal organisation of each practice (RCGP, 2016 (https://www.rcgp.org.uk/getmedia/11f26527-5d11-47f2-a593-1a894c2fff1b/Continuity-of-care-in-modern-day-general-practice1.pdf)).

We will continue our Medicines Safety Improvement Programme (https://www.england.nhs.uk/patient-safety/patient-safety-improvement-programmes/#MedSIP) and want to enable more patients to stop or reduce their use opioids for chronic non-cancer pain management, which will then reduce harm from high dose opioid prescribing (https://www.england.nhs.uk/south/info-professional/safe-use-of-controlled-drugs/opioids/). We want general practice and community pharmacy to continue work together to improve the reviewing and optimisation of direct oral anticoagulants (DOACs) for patients. We want general practice and community pharmacy to proactively discuss the anticoagulant medicine (https://www.england.nhs.uk/long-read/community-pharmacy-oral-anticoagulant-safety-audit-2021-22/) with the patient or representative to ensure safe and effective use, including the signs of over-anticoagulation, as we know involving patients in their own care improves safety.

We want to identify and share best practice in safety critical administration processes (Avery et al, 2020 (https://qualitysafety.bmj.com/content/30/12/961)) to enable prompt referrals and timely information sharing.

Opportunities

As part of the CQC's inspection of general practices, it completes searches for information on patient outcomes, medications and potential missed diagnoses. General practices have been able to access these searches since 2002 via EMIS, SystmOne, Vision clinical systems and the Ardens CQC website (https://www.ardens.org.uk/cqc/), and so practices can use them to chart the effectiveness of interventions to improve patient safety and understand where there may be further areas for improvement.

The Health Services Safety Investigations Board's (HSSIB) Continuity of care report (2023) (https://www.hssib.org.uk/patient-safety-investigations/continuity-of-care-delayed-diagnosis-in-gp-practices/) highlighted that patients who visit their GP practice with an ongoing health problem may see several different GPs about the same symptoms. It recommended that GP practices should have a system in place to ensure they deliver continuity of care, with a proposal to amend the GP IT standards to ensure that patients who visit their GP practice multiple times with unresolved symptoms are identified and prioritised. A renewed focus on continuity of care described in the blog by the Royal College of General Practitioners (2021) (https://www.rcgp.org.uk/blog/continuity-of-care-work-at-rcgp) should also help reduce the pressures facing general practice and the wider health system (Pereira Gray et al, 2023 (https://www.bmj.com/content/383/bmj-2022-074584#:~:text=Published%20reports%20of%20practices%20with,support%20for%20changes%20in%20organisation.)). This will enhance the changes being put in place by practices embedding the modern general practice model and so better match the right capacity to need which includes continuity of care where relevant.

Case study 9: Continuity of care in general practice in Devon

The project team (https://www.continuitycounts.com/the-team) improved and measured continuity of care (https://www.continuitycounts.com/continuity-measurement) between patients and their named GP at 5 Devon general practices. They also now promote continuity more widely by increasing awareness of the benefits for patients, doctors and health systems, helping practices to measure continuity and promoting the use of personal lists.

One of the recommendations from the overview on the first year of the Clinical negligence dcheme for general practice (2022) (https://resolution.nhs.uk/wp-content/uploads/2022/08/3523-CNSGP-Report-DV5-SINGLE-Access-1.pdf) was that patients on cardiovascular drugs, antipsychotics and opioids are prioritised for structured medication review within a primary care network's Directed Enhanced Service (DES). Further information on medicines improvement is also available via the Pharmacy Quality Scheme (PQS) open data portal (https://opendata.nhsbsa.net/dataset/pharmacy-quality-scheme-data-2022-23).

Case study 10: Pharmacy Quality Scheme (PQS)

The PQS has been used as a tool since 2016 to improve patient safety in pharmacy, generating regular patient safety reports, recommendations and training (https://cpe.org.uk/quality-and-regulations/pharmacy-quality-scheme/pharmacy-quality-scheme-outcomes/). In 2023, Community Pharmacy England, NHS England and the Department of Health and Social Care won the HSJ Patient Safety Team of the Year Award (https://cpe.org.uk/our-news/pqs-hsj-award-recognises-patient-safety-work-of-the-community-pharmacy-sector/#:~:text=PQS%3A%20HSJ%20Award%20recognises%20patient%20safety%20work%20of%20the%20community%20pharmacy%20sector,-CPCF%7COur%20Work&text=Earlier%20this%20week%2C%20Community%20Pharmacy,(HSJ)%20Patient%20Safety%20Awards.) for the PQS work relating to: non-steroidal anti-inflammatory drugs; anticoagulants; the medicines safety for lithium, methotrexate, amiodarone and phenobarbital; the TARGET antibiotic checklist; and the TARGET Treating Your Infection leaflets. This resulted in clinical advice being given 385,000 times to improve medicines safety and pharmacy teams identifying 90,000 people at sufficiently high risk to require referral or a clinical intervention.

In providing the Discharge Medicines Service (DMS) (https://www.england.nhs.uk/primary-care/pharmacy/nhs-discharge-medicines-service/) community pharmacy ensures changes to a patient's medication when they leave hospital are more reliably communicated to other primary care providers and the patient. DMS helps reduce problematic polypharmacy and patient readmissions. There are still opportunities for improved collaborative DMS working with the development of referral pathways across hospitals, primary care and community pharmacy (https://cpe.org.uk/national-pharmacy-services/essential-services/discharge-medicines-service/).

Tools for recognising and responding to deterioration in patients are well established as a key component of improving patient safety in secondary care. The RESTORE2 (https://wessexahsn.org.uk/projects/329/restore2) tool has been implemented in care and nursing homes as a physical deterioration recognition and escalation tool. This is based on nationally recognised methodologies including early recognition (soft signs), the National Early Warning Score 2 (NEWS2) and structured communications (SBARD).

The 2023 National confidential enquiry into patient outcome and death review (https://www.ncepod.org.uk/2023transition.html) identified primary care as a key area for safety netting in the transition of children and young people with complex chronic health conditions into adult health services. To improve patient safety primary care should be involved throughout this transition, providing continuity of care and addressing any wider health concerns.

Local commitments

1. ICBs and GP practices to pilot approaches and share good practice for locally-derived patient safety improvements relating to the 3 patient safety themes of: diagnosis, medication and referral.

2. Community pharmacies to continue to implement the Pharmacy Quality Scheme (https://cpe.org.uk/quality-and-regulations/pharmacy-quality-scheme/pharmacy-quality-scheme-outcomes/) (PQS) improvement initiatives and to identify, develop and test novel approaches, and share good practice for locally-derived patient safety improvements.

3. Optometry services and dental services to identify, develop and test novel approaches, and share good practice for locally-derived patient safety improvements.

National commitments

The National Patient Safety team, working with relevant NHS England teams and partners, will:

1. Review the 3 general practice patient safety themes – diagnosis, medication and referral – and develop and test novel approaches for improvement and share good practice.

2. Develop and publish guidance on best practice for safety critical process in general practice (Avery et al 2020 (https://qualitysafety.bmj.com/content/30/12/961)), for example handling correspondence and results.

3. Review approaches and consider priority groups for improved continuity of care and test novel approaches and measurements for improvement and share good practice.

4. Identify and review patient safety themes in community pharmacy, optometry services and dental services to develop and test novel approaches for improvement and share good practice.

Appendix 1: Summary of local patient safety commitments

Safety culture, safety systems and inequalities

1. General practice with ICBs support to give staff the opportunity to complete the NHS general practice Staff Survey (Information on Future NHS (https://future.nhs.uk/connect.ti/StaffExperienceandEngagement/view?objectID=44865008)), and general practice to act on the published survey findings to improve safety culture and staff experience.

2. Community pharmacy, optometry and dental service providers to support staff to complete local staff surveys where available and to act on the survey findings to improve safety culture and staff experience.

3. All staff and students (clinical and non-clinical) in primary care to have access to complete the free online NHS patient safety syllabus training levels 1 and 2 (https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/) (with a primary care-specific module). This training includes information on safety culture, human factors and ergonomics, just culture and incidents. It can be accessed by those without an nhs.net address and takes around 1 hour to complete.

4. ICBs should ensure primary care staff have access (https://www.england.nhs.uk/ourwork/freedom-to-speak-up/integrated-care-boards-integrated-care-systems-and-freedom-to-speak-up/) to FTSU guardians who are independent to the provider practice.

5. ICBs to identify digital clinical safety officers and provide effective digital and implementation support and training to primary care to enable benefit realisation, as detailed in the GPIT operating model (https://www.england.nhs.uk/digitaltechnology/digital-primary-care/gp-digital-services-operating-model-21-23/), the delivery of quality functions in ICSs (May 2024) (https://future.nhs.uk/ICSQualityHub/view?objectId=122926341) and the digital clinical safety strategy (https://www.nhsx.nhs.uk/key-tools-and-info/digital-clinical-safety-strategy/) (2021.

6. ICBs to procure safe digital products for general practice that meet quality assured standards (including DCB0129 (https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb0129-clinical-risk-management-its-application-in-the-manufacture-of-health-it-systems)) and to ensure they are highly usable and accessible for patients and the workforce.

Insight

1. ICB quality groups/committees and patient safety specialists to develop mechanisms that support the adoption of LFPSE and PSIRF in primary care, sharing of insight and learning, and improve communication across systems for primary care. ICBs should explore sharing using existing structures such as buddying/peer systems for practices/organisations, and PCN-based patient safety groups.

LFPSE service:

2. All ICBs, general practices, community pharmacies, optometry providers and dental providers to register for an administrator account (https://record.learn-from-patient-safety-events.nhs.uk/) with LFPSE or to connect their local risk management system (https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fpatient-safety%2Fpatient-safety-insight%2Flearning-from-patient-safety-events%2Flearn-from-patient-safety-events-service%2Flrms-suppliers%2F&data=05%7C02%7Chester.wain%40nhs.net%7C7ccd4dc32ca04c882aea08dc3e943b8a%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638454053567915706%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=TGqvUteH7CHF4m2KAnke8af5fV7VF3CVPCXzoOnNhdg%3D&reserved=0) to LFPSE to ensure that patient safety events are recorded on the national system. This will enable learning that supports local and national patient safety improvement.

3. All ICBs, general practices, community pharmacies, optometry providers and dental providers to provide user feedback (mailto:england.patientsafetyhelpdesk@nhs.net) to LFPSE on how to improve the interface.

4. Primary care providers to encourage individual practitioners to register (https://record.learn-from-patient-safety-events.nhs.uk/) with LFPSE so that they can record and access their records via the LFPSE data access app (https://access-data.learn-from-patient-safety-events.nhs.uk/) for use in appraisal and revalidation.

PSIRF:

5. General practice, with support from ICBs, to start implementing the Patient Safety Incident Response Framework (https://www.england.nhs.uk/patient-safety/incident-response-framework/) (PSIRF) that is proportionate, flexible and contextual. This could be at place or via GP federations or PCNs. Community pharmacy, optometry and dental service providers should also start to implement PSIRF where they feel confident to do so.

Involvement

1. GP, dental, pharmacy and optometry practices, place or PCNs start to identify patient safety leads and enable them to complete the free online NHS patient safety syllabus training (https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/) levels 1 and 2 (with primary care module).

2. GP, dental, pharmacy and optometry practices or PCNs start to identify two or more lay Patient safety partners (PSPs) in line with the framework for involving patients in patient safety (https://www.england.nhs.uk/publication/framework-for-involving-patients-in-patient-safety/), and enable them to complete the free online NHS patient safety syllabus training (https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/) levels 1 and 2 (with primary care module).

3. General practices to add patient safety to their PPG agendas.

4. ICB Patient safety specialists (PSSs) to provide guidance and support for the local implementation of patient safety leads and PSPs.

Improvement

1. ICBs and GP practices to pilot approaches and share good practice for locally-derived patient safety improvements relating to the 3 patient safety themes of: diagnosis, medication and referral.

2. Community pharmacies to continue to implement the Pharmacy Quality Scheme (https://cpe.org.uk/quality-and-regulations/pharmacy-quality-scheme/pharmacy-quality-scheme-outcomes/) (PQS) improvement initiatives and to identify, develop and test novel approaches, and share good practice for locally-derived patient safety improvements.

3. Optometry services and dental services to identify, develop and test novel approaches, and share good practice for locally-derived patient safety improvements.

Appendix 2: Summary of national patient safety commitments

Safety culture, safety systems and inequalities

1. Co-design primary care examples of just culture, thus improving the response to safety events and reducing any fear of safety event recording.

2. Promote a systems approach (and not an individual approach) as the appropriate response to patient safety incidents in primary care (working with regulatory bodies such as CQC, GMC, GDC, GOC, GPhC, NMC and PAG and other partners such as HSSIB and NHSR).

3. Review the data from the new NHS general practice Staff Survey and understand the responses to the patient safety questions to identify areas for patient safety improvement.

4. Promote areas identified as priorities for digital decision support and support the continuation of work on digital interoperability for primary care settings.

5. Oversee the progress and impact of safety culture actions and the person-centred safety improvement plan in relation to primary care.

6. Produce a patient safety healthcare inequalities reduction handbook for primary care that supports individuals to make effective changes.

7. Develop the Learn From Patient Safety Events (LFPSE) service to record protected characteristics of those involved in patient safety events to identify improvements to reduce healthcare inequalities in primary care.

8. Provide ICBs with best practice examples of FTSU guardian models within primary care.

Insight

1. Continue to explore opportunities to enhance national and local learning in primary care by identifying how the LFPSE service can best record and share data, and learn from patients, service users, families and carers who have experienced a patient safety event.

2. Continue to work with patients, service users, families and carers to understand their needs and what further resources can help support the future roll-out, adoption, and user-friendliness of a patient-facing LFPSE service.

3. Provide guidance and examples of how PSIRF principles can be applied in primary care.

4. Develop a patient safety primary care communications plan that identifies the optimum pathways for patient safety information dissemination to primary care; for example, via national primary care commissioning broadcast cascade, or ICS or regional communication.

5. Continue working with Project Sphere (https://www.england.nhs.uk/primary-care/dentistry/leading-the-change/patient-safety/) to develop opportunities to share patient safety events learning, along the lines of the forum provided by the Community Pharmacy Patient Safety Group (CPPSG) (https://pharmacysafety.org/) for open sharing of things that go wrong in community pharmacy.

6. Explore incentivising patient safety (such as with leadership, training or protected time) through national or local schemes and contractual levers

7. Co-develop flexible and contextual guidance for patient safety partner recruitment across primary care.

8. Use the framework for involving patients in patient safety (https://www.england.nhs.uk/publication/framework-for-involving-patients-in-patient-safety/) to develop patient involvement in community pharmacy (working with Community Pharmacy England and local pharmaceutical committees), dental (working with Project Sphere and local dental committees) and optometry services (working with local optometry committees).

9. Provide clear guidance to ICB PSSs on how they should prioritise cross-system support for primary care.

10. Review the efficacy of different ICB models for PSSs dedicated to primary care, for example a general practice PSS, or an area specific PSS located at PCN level. This review will generate examples of good practice that will be shared with ICBs.

11. Co-develop flexible and contextual guidance for the development of patient safety leads in primary care at, as a minimum, PCN level, and link them to PSS networks for support.

12. Review opportunities to add patient safety training to the continued professional development (CPD) requirements for community pharmacy, optometry and dental services via GPhC, GOC, GDC and NMC.

13. ICBs to procure safe digital products for general practice that meet quality assured standards and to ensure they are highly usable and accessible for patients and the workforce.

Improvement

1. Review the 3 general practice patient safety themes – diagnosis, medication and referral – and develop and test novel approaches for improvement and share good practice.

2. Develop and publish guidance on best practice for safety critical process in general practice (Avery et al, 2020 (https://qualitysafety.bmj.com/content/30/12/961)), for example handling correspondence and results.

3. Review approaches and consider priority groups for improved continuity of care and test novel approaches and measurements for improvement and share good practice.

4. Identify and review patient safety themes in community pharmacy, optometry services and dental services to develop and test novel approaches for improvement and share good practice.

Publication reference PRN01039

Date published: 26 September, 2024
Date last updated: 2 October, 2024

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